

**ILLINOIS DEPARTMENT OF LABOR**

524 S. 2nd Street, Suite 400

Springfield, IL 62701

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<http://labor.illinois.gov/>**PLEASE PRINT OR TYPE ALL INFORMATION**

Use additional sheets if necessary. Attach copies of all supporting documentation and other evidence.

FOR OFFICE USE ONLY: Claim Number

Received

EQUAL PAY COMPLAINT FORM**I. EMPLOYEE INFORMATION:**

Last name: First name: Initial: Male Female

What is your race:

Address:

City: State: Zip code:

Home phone number: Work phone number:

Date you were hired: Your last day worked:

Your job title with employer: Start date in title: End date in title:

II. EMPLOYER INFORMATION:

Employer Name: Is this employer still in business? Yes No

Address:

City: State: Zip code:

Corporation name, if any: Number of employees:

Employer contact name: Contact phone number:

Name of your direct supervisor: Industry of employer:

Name and title of person(s) interviewed with:

III. CAUSE OF DISCRIMINATION:

1. Were you asked for your prior salary or benefits?	Yes	No	If yes, date of the prior salary inquiry:
2. Were you underpaid because of your gender?	Yes	No	If yes, date of underpayment:
3. Were you underpaid because of your race?	Yes	No	If yes, date of underpayment:
4. Did you experience retaliation?	Yes	No	If yes, date(s) of retaliation:

IV. EMPLOYMENT INFORMATION:

1. Did you sign an employment contract or agreement? Yes (if yes, attach a copy) No 2. Were you an independent contractor? Yes No

3. Employment status with this employer? Quit Discharged Still employed Was not offered employment

4. If discharged, state reason:

5. If not offered employment, state reason:

6. Did you supervise anyone? Yes No

7. Did your job require a college degree, formal education, or training? Yes No If yes, specify:

8. What type of work did you perform? (For example: carpentry, data entry, nursing)

9. List primary duties and responsibilities:

A. C.

B. D.

10. Address, city, state and zip code where work was performed?

11. In what county was your work performed? 12. Rate of pay: \$ per

13. How often were you paid?: Weekly Bi-Weekly Monthly Semi-Monthly Other (explain:)

14. Other type of compensation (Check all that apply):

Vacation Pay Sick Leave Holiday Pay Overtime Pay Health/Life Insurance Commissions

Pension/401K Profit Sharing Bonus Other (describe:)

V. COMPLAINT DETAILS & STATEMENT OF FACT:

1. In the space provided below, please state the facts concerning the alleged violation. Please be as specific as possible. Attach additional sheets if needed.

2. In the space provided below, please identify each specific harm you have suffered as a consequence of the alleged violation, including the date(s) and place(s) in which the alleged violations occurred. Attach additional sheets if necessary.

Specific Harm

Date(s)

Place(s)

3. Are any of the matters listed above pending in State or Federal court?

Yes No If yes, explain:

4. Are any of the matters listed above pending at the Illinois Department of Human Rights or the EEOC?

Yes No If yes, explain:

5. Please provide the name and telephone number of someone who will know how to reach you:

Last name:

First name:

Phone number:

Relationship:

VI. CERTIFICATION & SIGNATURE:

I HEREBY CERTIFY that the statements herein, including attachments, are true and accurate to the best of my knowledge and belief. I UNDERSTAND that acceptance of this complaint by the Illinois Department of Labor does not guarantee collection. I AUTHORIZE the Department of Labor to receive any monies paid and to mail such monies to me at my own risk.

Date:

Employee Signature: